DOCUMENT RESUME

ED 313 613 CG 022 136

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TITLE Aging in Israeli Society--A Growing Dialogue between Research and Practice.
INSTITUTION International Exchange Center on Gerontology, Tampa, FL.
PUB DATE 87
NOTE 30p.
PUB TYPE Reports - Descriptive (141)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Aging (Individuals); Foreign Countries; Judaism; Migration; Population Trends; *Research and Development; *Theory Practice Relationship
IDENTIFIERS *Israel

ABSTRACT

This document presents a short description of the demographics and unique features of aging in Israeli society and a discussion of two research projects in the area of aging and the implications of the findings for policy and service development. It is noted that the elderly comprise approximately 10% of Israel's Jewish population and that the majority of Israel's Jewish elders are foreign-born. The discussion examines the ethnic and cultural diversity of Israel's population and the impact of this diversity on living arrangements, family relations, and care for the elderly. A dichotomy is drawn between ethnic groups with Western modern cultural backgrounds and those from Asia and Africa with the background of Eastern traditional culture and norms. Also examined are the living environments in Israel, especially within the rural sector where traditional villages exist alongside cooperative villages (the moshav) and collective communities (the kibbutz). The main components of the state of the art in gerontology in Israel are outlined. The first research project described involves an evaluation of the welfare services of the Haifa municipality and a coordinating service network between the hospitals in the city and the welfare department. The second project deals with the impact of the decision-making process of institutional placement upon family relations and the role of the social worker in the process. (NB)

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AGING IN ISRAELI SOCIETY -- A GROWING DIALOGUE BETWEEN RESEARCH AND PRACTICE

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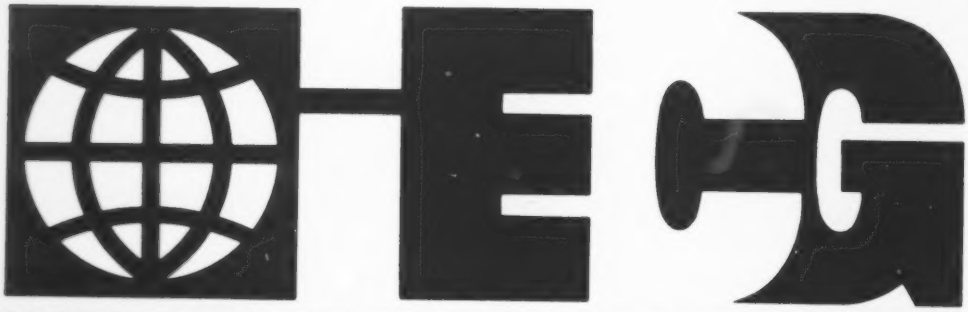

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AGING IN ISRAELI SOCIETY
-- A GROWING DIALOGUE BETWEEN RESEARCH AND PRACTICE

By

Ariela Lowenstein, Ph.D.

Haifa University and

The Brookdale Institute of Gerontology

and Adult Development in Jerusalem

Published by the International Exchange Center

on Gerontology at the University of South Florida

Tampa, Florida

1987

Foreword

The International Exchange Center is happy to publish the lecture on aging in Israel given at the University of South Florida in mid-1987 by Professor Ariela Lowenstein of Haifa University and the Brookdale Institute in Jerusalem. Florida and Israel resemble each other not only in terms of climate, but also in terms of demography: both have had large numbers of elderly immigrants of diverse backgrounds and geographical origins. Both have experienced problems associated with the immigration of older men and women. Roughly 25 percent of the early post-World War II immigrants to Israel were 50 and older. The communities and governments of each continue to search for improvements in the provision of health and social services to older individuals and their families.

Israel's proportion of elderly in its Jewish population places that country among the 30 or so countries of the world with 10 or more percent of their populations 65 and older. Such a proportion is a phenomenon unique to the contemporary world. This proportion applies only to Israel's Jewish population; the figure for the Arab population is only 4 percent. But, as in the case of many "modernizing" urban-industrial societies, there is a trend in general in "non-Western" and/or previously rural populations toward the overall patterns of lower fertility and family structure changes.

In her lecture, Professor Lowenstein reminds us, furthermore, of the heterogeneity within the Israeli Jewish population itself. The immigrants to that country have not come from Europe alone. Many of us forget or are unaware that large numbers of Jews left (and/or were forced to leave) predominantly Arab countries in North Africa, for

example. Ethiopia, Yemen, Iran and Afghanistan, too, are represented in the modern-day population of Israel. The result is a mosaic of nationalities, cultures and unrelated languages in "the" elderly population. This is further compounded by a somewhat uniquely Israeli phenomenon -- the kibbutz and the rural cooperative -- each of which has its own population age-profile. The common element, however (and this characterizes all societies), is the importance of the family as the source of primary support systems. This prevails even in countries noted for being "welfare states," with substantial state participation in providing formal social and health services.

Dr. Lowenstein's address covers not only the demographic features of the Israeli situation, it is also a succinct description of major organizations -- public and private -- that have created, encouraged, and maintained a wide array of programs for the elderly. The Brookdale Institute of Gerontology and Adult Development in Israel, under the leadership of Dr. Jack Habib (originally from Florida), is the pre-eminent Israel institution that links the world of knowledge-creation, policy research, administration and practice -- universities, social agencies, and government.

The International Exchange Center on Gerontology -- a multi-university entity involving eleven universities in Florida -- has been fortunate to have inaugurated an ongoing program with the Jerusalem-based Brookdale Institute. The main Florida locus of the effort is centered in Miami, at Florida International University's Southeast Florida Center on Aging, directed by Max Rothman.

Professor Lowenstein's visit to Florida and her formal lecture presented in the following pages are part of our program to build and

expand that "Florida-Israel Connection." The two research projects she summarizes, and her discussion of their policy and service implications, should be of interest to gerontologists in general, and specifically to persons interested in Israel's population aging issues. It is only one of many events and projects that we hope will be among the fruitful outcomes of the exchange program. Cooperative research; policy-related seminars; study tours; publications; and exchanges of faculty, students and other professionals in the field of aging are among those intended outcomes.

Harold L. Sheppard
Director and Professor of Gerontology

AGING IN ISRAELI SOCIETY - A GROWING DIALOGUE BETWEEN RESEARCH AND PRACTICE

Ariela Lowenstein, Ph.D
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This paper includes two parts: the first, a short description of the demographics and unique feature of aging in Israeli society. The second, a discussion of two research projects in the areas of aging and the implications of the findings for policy and service development.

The philosopher, Isaiah Berlin, in his book Four Essays on Liberty (1969) conceptualized freedom as encompassing two basic elements: being free from constraints, and having a variety of alternatives when faced with major life decisions. In our service delivery system for the aged in Israel, we try to work along these lines. This especially important in a country where the variability and diversity of the population, including the aged, is so pronounced.

Israel as a country and a society perceived itself as youth oriented, vigorous, oriented towards building a new homeland for the Jewish people. However, in the last decade Israel has become an aging society with many characteristics of industrialized countries in regard to problems of the aged. In 1948 when the state was created,

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*During 1987, a visiting scholar at the Brookdale Institute of Gerontology and Adult Human Development in Jerusalem. This report is based on a lecture at the University of South Florida, in May, 1987.

the elderly were 3 percent of the population. In 1985 their percentage in the Jewish population has increased to about 10 percent, numbering some 400,000 persons. In some cities, like Tel-Aviv and Haifa, the elderly comprise 15-20 percent of the population. The composition of the aged population has been changing as well. The principal source of Israel's growth and the central context of its existence has been immigration. Only a small percentage (about 7 percent) of the Jewish aged are locally born; the majority are foreign-born, who came to Israel in their later years. These groups demonstrate a variety of attitudes and life styles. The "internal process of aging" is also quickening. The 'old-old' -- those 75+ -- are increasing among the aged (from 28.6 percent in 1950 to 40.1 percent in 1990). This means that we have to address ourselves to the changing needs of the aged and change, expand and create more services. Table 1 presents the demographic distribution of the different age groups within the Jewish aged population, comparing it with the aged living in institutional settings. As can be seen from the table, the overall institutionalization rate is 3.6 percent, which is low compared to other Western countries. However, it increases with age and reaches 20 percent for those 85+ (Bergman, Factor and Kaplan, 1986).

The demographic picture presented above is different for the non-Jewish population which is still young, its elderly comprising only 4 percent. However, the structure and norms of their traditional society are also changing. Fertility rates are decreasing and the traditional family fabric is moving in the direction of more modernized industrialized societies (Weill, 1986).

Table 1: Jewish Aged 65+ in Israel and in Long-Term Care Institutions and Rate of Institutionalization per 1000 aged, According to Age

Age Group	Long-Term Care Institutions		General Aged Population		Institutionalization rate per 1000 Aged
	Total	Percentage	Total	Percentage	
Total	12,155	100	337,834	100	35.9
65-69	621	5	109,054	32	5.7
70-74	1,643	14	110,087	33	14.9
75-79	2,747	23	66,758	20	41.9
80-84	3,487	29	34,959	10	99.7
85+	3,410	28	16,976	5	200.9
Unknown	247	2	-	-	-

Against this background, I shall briefly address and discuss two of the more unique aspects of Israeli society and their implications for the area of aging. The first issue is the ethnic and cultural diversity and its impact on living arrangements, family relations and care for the elderly. We can dichotomize between ethnic groups with Western modern cultural background -- the Euro-American population, and those from Asia-Africa with the background of Eastern traditional culture and norms. Among the aged, today, about 70 percent come from Europe and the West and about 25 percent from Asia-Africa. Elderly with Western backgrounds prefer living on their own while a large percentage of those with traditional backgrounds live in a shared household of a son or a daughter, where being cared for by children is part of the normative expectations. In the two cultures, however, the family continues to be a major informal support network, especially in crisis situations. Various surveys (Zliberstein, 1981; Shuval, 1982) indicate that 80 percent of elderly living in the community who need assistance and care receive it primarily from their children. Elderly from Asia-Africa fare better because they have larger families. Whereas international patterns suggest substitution between family and other sources of informal support, in Israel it is still much more family centered (Habib, 1986). Family composition and family status also affects rates of institutionalization as we can see from Table 2. Whereas 8.2 percent of single persons are in institutions, only 1 percent of the married live there. Widowhood also affects institutional rates; 7.3 percent of widowed elderly reside in long-term care facilities. While cultural differences are still discernible in care giving patterns there s a trend towards autonomous

Table 2: Jewish Aged 65+ in Israel and in Long-Term Care Institutions and Rate of Institutionalization per 1000 Aged, According to Marital Status

Marital Status	Long-Term Care Institutions		General Aged Population		Institutionalization rate per 1000 Aged
	Total	Percentage	Total	Percentage	
Total	12,155	100	337,834	100	35.9
Married	2,049	17	203,273	61	10.1
Single	635	5	7,740	2	82.0
Divorced	402	3	8,092	2	49.7
Widowed	8,671	71	118,729	35	73.0
Unknown	398	3	-	-	-

households also within the Asian-African groups. These changes, though, do not affect the content and intensity of intergenerational contacts. Moreover, we find in Israel patterns of intergenerational resource transfer which are very strong, mainly because of the need to finance housing ownership which is the norm.

The second unique aspect of Israeli society is reflected in its living environments, especially within the rural sector. In this sector we find a mixture of traditional villages and modern rural communities of two types, both unique to Israel: the cooperative villages (the moshav) and the collective communities (the kibbutz). Work and collective sharing were central values in kibbutz life. Being work oriented, the kibbutz does not have a mandatory retirement age but adopted phased retirement and a flexible work policy. Most of those over 65 continue to work. The communal life compensates for the separate living arrangements and permits new patterns of kinship and more intergenerational contact, having three or four generations living in close proximity.

Against the above background we can consider the state of the art of gerontology in Israel. I would consider two dimensions: one is theoretical knowledge-creation and dissemination; the second, the practice level -- policy formulation and service development. The first decade of Israel's existence was characterized by emphasizing practice developments because of the priority to tackle practical care problems. The creation of ESHEL (The Association for Planning and Development of Services for the Aged in Israel) in 1969 provided the "impetus" for a rapid development in the neglected area of services for the aged. Eshel is a unique organizational "creature" created as

a joint venture by the Joint Distribution Committee and the Israeli Government on the basis of matching funds. Eshel is relatively a small organization operating mainly through various professional committees, each committee composed of experts from the field. it has become the leading organization in service development and manpower training.

On the level of knowledge creation and dissemination, we can distinguish two periods: until 1970, when the major research interests were (1) the special characteristics of Israeli society and issues in regional "pathology and morbidity" in a culturally diverse immigrant society (Bergman, 1979); and (2) since 1970, especially after the creation of the Brookdale Institute for Research and Development which is the central research institute in the area of aging in Israel. The Brookdale Institute is affiliated with all the other institutes of higher education in Israel, and I have spent by 1987 sabbatical year in Brookdale. Knowledge creation is also reflected in the growing number of publications, and the publication of an ongoing gerontological quarterly. The number of professionals working and doing research is growing and in the last conference of the Israeli Society of Gerontology, which celebrated its 30th birthday, there was an attendance of about a thousand members.

There are seven institutes of higher learning in Israel and gerontology is researched and taught in all of them. In the Weizman Institute and the Israeli Technion, the emphasis is on basic research, especially in biology, bio-chemistry and medicine. In the other universities there is more of an emphasis on applied research, and gerontology and geriatrics are taught. There are no degree programs

yet in gerontology since it is not recognized as an academic discipline, or as a discipline that should have a department by itself. However, there are specializations in gerontology, mostly on the undergraduate level. To mention some: in the Schools of Social Work at Tel-Aviv and Haifa universities, in the department of Psychology and School of Nursing at Tel-Aviv. In recent years there is an expansion of different training programs within the framework of continuing education units in the universities. For example, in the last five years I have been running a national two-year certificate program for directors of old age and nursing homes.

In Haifa the School of Social Work in cooperation with the School of Medicine at the Technion are working on developing a joint masters program in gerontology and geriatrics, with three tracks: basic research, clinical and applied research and teaching, and administration. In my meetings in Florida, someone asked me how do we from the School of Social Work get along and work on a joint program with the School of Medicine. I think the answer is based on the conception that gerontology is interdisciplinary and the human service professions must work together to develop it as a discipline.

So far I presented some of the data on the demographic structure of Israeli society as well as some of the unique elements. In addition, I tried to outline the main components of the state of the art of gerontology in Israel. Below I will describe two of the research projects I have been conducting, one several years back and the other in 1986 with the cooperation of the Brookdale Institute.

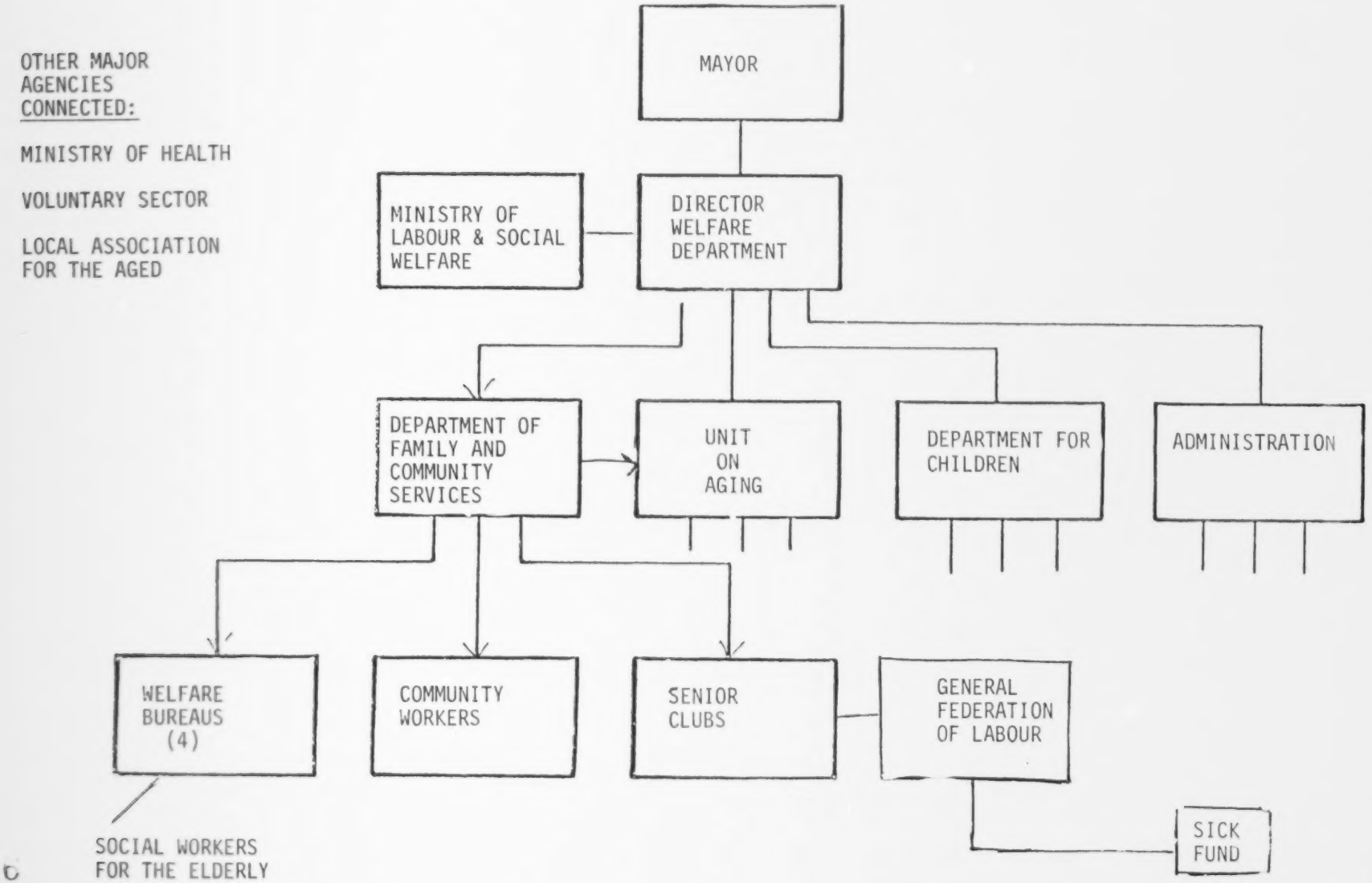
The first research project was an evaluation of the welfare services of the Haifa municipality with the goal of helping them to

develop a five year master plan for the department. This research reflects the links between academia and the field, and the impact of research on policy formulation and service development. The project started in 1979 when the mayor and the new director of the welfare department of Haifa municipality felt that the area of services for the aged is neglected, and that comprehensive evaluation and program planning is needed. There were three elements which made me undertake this research: first, my need to learn more systematically about the services and the grassroots problems of the workers in the field; second, my role in the School of Social Work at the Haifa University as head of the aging programs trying to develop a curriculum, field placements and a network of high caliber supervisors; third, I felt the time was ripe to put aging as a service and learning issue on the map and thus attract more competent workers and students to this field.

What was the rationale of the municipality? Again, I could think of three components: first, the director of the welfare department was new and wanted to introduce changes; second, cooperation with the university provided a status base; and third, he recognized the vacuum in the area of services for the elderly and the need for changes and systematic development.

Figure 1 presents the organizational structure of the welfare department within the municipality and its links to the other major organizations operating in the area of services for the elderly: the Ministries of Labour and Welfare and Health; the General Federation of Labour (the Histadrut) through the senior clubs and the local association for the elderly. Just a few words about the local

Figure 1: ADMINISTRATIVE STRUCTURE OF WELFARE DEPARTMENT, HAIFA



association which is a very unique type of agency. It was created by the Association for Planning and Development of Services for the Aged in Israel (ESHEL) in many communities and they include representatives from all the service network working together to coordinate, integrate and plan new projects when the need arises. From the organizational structure presented in Figure 1, one can see that lines of responsibility are not clear and there is a lot of overlapping in service provision. My mandate was to evaluate the services for the aged provided by the welfare department as well as to map unmet needs in the community.

The study included the following research populations: (1) the directors of the different relevant departments within the municipality and the welfare department, including the directors of the four welfare bureaus and those in charge of the twenty senior clubs; (2) the 18 social workers working with the elderly in the welfare bureaus; (3) a representative sample of client files from the welfare bureaus; and (4) a cluster sampling from the elderly in the community who were not in contact with the welfare bureau.

Three research instruments were devised for the study: The first, a short simple instrument to map all the services provided by the welfare department. In addition, we also did participant observation in a random sample of the services. Trained social work students were sent to sit in on worker-client meetings, staff meetings and record it.

Qualitative as well as quantitative analysis was performed on these observations. On the basis of these data we built demographic and functional profiles of the clients served. In the second stage,

all the social workers in the welfare bureaus working with the aged were asked to classify their files into four groups according to intensity of treatment, from very intensive to low according to frequency of meetings per month. Then we sampled randomly 25 percent from each of the four groups and examined 350 files. On each file the workers had to complete a short instrument which included socio-demographic data, data on health status - ADL activities, mobility, etc., contact and assistance from support network, types of services furnished by the welfare department and an evaluation on additional services needed. In order to understand and evaluate the needs of elderly in the community who were not in contact with the services, we did a community survey. The elderly comprise 16 percent of the Jewish population of Haifa, numbering about 35,000. We did a cluster sampling, each borough serving as a cluster, and from each cluster sampled randomly 2 percent of the aged. The sample was drawn on the basis of the National Insurance Institute files. Data were gathered by personal interviews, using the Placement Information Base developed by Saslow and Yamodis (1970) in Oregon. The instrument was pre-tested and adapted to Israel.

The main findings of the community survey indicate that about half of the respondents had problems in mobility, about a third had communication problems, and close to 60 percent evaluated their health as "not good". About half had difficulties in managing the home, including shopping, food preparation, etc. These are connected to the relatively high percentage of the "old-old" in two of the boroughs. Close to half of them did not know about the existing network of social services and close to 80 percent had no knowledge about other

municipal services. From amongst those who were familiar with the services, only about 15 percent had utilized any of them.

On the basis of the above data, we presented our recommendations which I would like to discuss and analyze. The analysis will include a short presentation of the process of implementing the recommendations as well as evaluating some of the outcomes. One of the basic suggestions was to create, within the welfare department, a special unit on aging. This unit, when established, will be responsible for staff training, setting criteria for service development, accountability, and for a more unified way of reporting. The unit was created and accorded authority over the workers in the department as well as some responsibility for the senior centers. The creation of the unit made a radical change in service provision, professionalization of staff and creation of many new services for the aged. I would briefly describe two such services which are rather unique. The first is an information placement service in the area of institutional placement open to the general public in Haifa and the surrounding area. It is open during a full working day once a week, and anybody can just walk in and be served. It is manned by a social worker and a trained nurse who have comprehensive information about all the long term care facilities in the area, including admission criteria, type of clientele and services provided, finances, duration of waiting, etc. It is basically geared to provide information and knowledge. When needed, however, a short intake is done and people are referred to the appropriate agencies. The workers try, as much as possible, to discourage people from making a quick decision about

institutional placement, trying to suggest other alternatives and to act as advocates and referral sources.

The second program is a coordinating service network between the hospitals in the city and the welfare department. There are three general acute hospitals in Haifa and a geriatric rehabilitation hospital. Some informal contact existed between the social workers in the hospitals and the workers in the community, but it was not systematic, formal and on an on-going basis. People who have a relationship with the health field know the problems, especially regarding elderly discharge when trying to activate the continuum of care: hospital-community services. In Israel when you discharge an elderly person, who might live alone, on a Friday afternoon he will come to a house where there might not be any food, and nobody to take care of him. He is in a bind. Thus, we tried to link the workers in the hospitals and those in the field. Joint meetings between the workers were organized to discuss alternative means of coordination and cooperation. On the basis of these meetings a special simple form was devised. When the workers in the hospitals are treating an elderly who they assess as being at risk (80+ years, lives alone, etc.) they will contact the worker in the community, send him the form which contains basic information about the elderly, his situation and needs and when they expect him to be discharged. A copy of this form is mailed to the unit on aging in the department, for the follow-up. In return the social workers from the welfare bureaus have to report to the workers in the hospital, on the same form about the treatment plan, again a copy being sent to the unit on aging. In periodic

meetings three and six months after this was implemented satisfaction was expressed by workers from both agencies.

To summarize, the main effects of the research were: (1) creation of a unit on aging with the welfare department of the municipality; (2) expanding manpower, with higher levels of expertise and new intervention techniques; (3) creation of new services for the elderly and improvement or changes in the existing services; (4) the beginning of a data base and the utilization of research material.

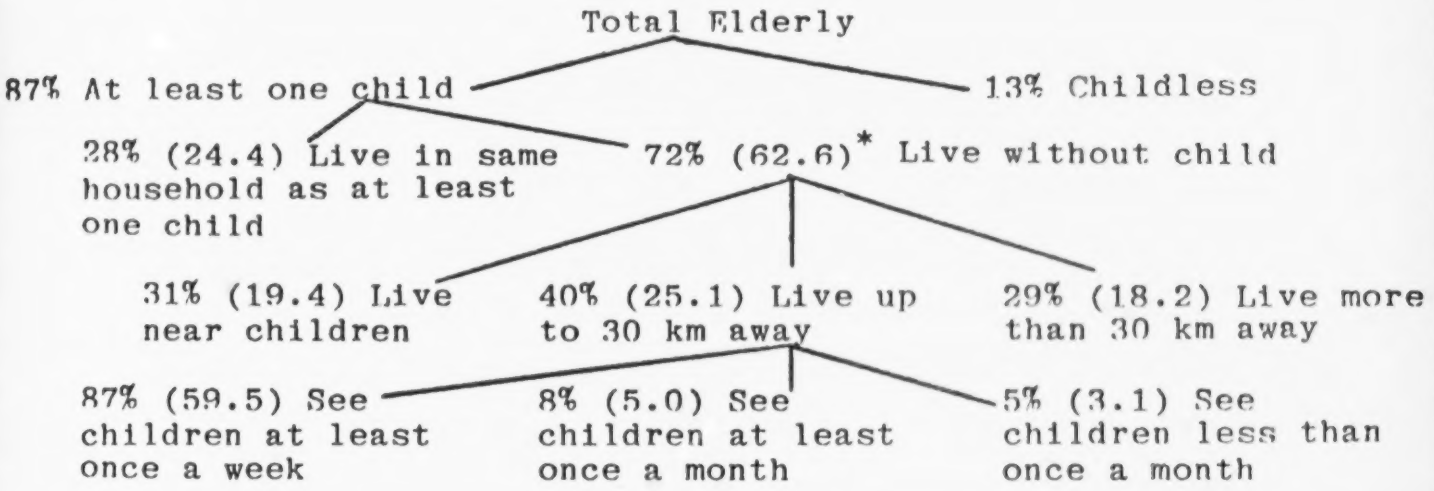
I have continued to work with the welfare department as a consultant after the research project was completed. In the first two years my involvement was intensive, developing training programs, workshops, etc., trying to change role models and to help them develop different treatment techniques, encouraging more outreach, interdisciplinary work and introducing elements of evaluation. After the first two years I started to limit my involvement and to concentrate on service development and special projects. After five years of working with the department they expressed the need for another systematic comprehensive evaluation. This corresponded to my sabbatical at Brookdale and the municipality made the decision to approach the University and the Brookdale Institute to prepare a ten year master plan for services for the aged.

The plan was undertaken soliciting the cooperation of all the agencies and organizations in the city providing services for the aged. A steering committee, headed by the mayor with representation from all the services involved was created to this effect. A comprehensive mapping of services as well as a thorough need assessment of elderly is under way.

The second research project deals with the impact of the decision making process of institutional placement upon family relations and the role of the social worker in this process. A preliminary report is available. Table 3 presents some data from a study done by Professor Shuval in one of the Jerusalem neighborhoods which clearly maps the state of family relationships of the elderly. These data can be applied to other communities, talking again about the Jewish population. From the table one sees that about 13 percent of the Jewish elderly are childless; 87 percent have at least one child. From amongst these 87 percent, 28 percent live in shared households with one of their children and the others live in independent households. In Israel we have a housing problem which complicates moving in with children and the tendency, if a crisis situation arises, to move near the children, reflecting the concept of "intimacy at a distance." Amongst the elderly living in independent households, a third live near their children and another 40 percent live up to 20 miles away. For those who live more than 20 miles away most see their children at least once a week. It has been documented, in several surveys, that about 40 percent of children caring for parents in the community were overburdened (Brodsky, 1986).

Why did I want to do this study? I worked in corrections before I started to work with the elderly. My practice and research, however, always centered on working with families and especially families in crisis situations. It seems that a decision about institutional placement is a process which starts with a crisis or changes in an elderly person's status. In addition, a new Nursing Law was passed in Israel in 1981 which is now in the process of

Table 3: The Set of Family Relationships of the Elderly


Total Elderly
87% At least one child
13% Childless
28% (24.4) Live in same household as at least one child
72% (62.6)* Live without child
31% (19.4) Live near children
40% (25.1) Live up to 30 km away
29% (18.2) Live more than 30 km away
87% (59.5) See children at least once a week
8% (5.0) See children at least once a month
5% (3.1) See children less than once a month

* Numbers in parentheses indicate percentages of total elderly.

Source: Shuval, Judith T., el al. Informal Support of the Elderly: Social Networks in a Jerusalem Neighborhood, Brookdale Institute, Jerusalem, 1982.

implementation. The idea underlying the law is to provide to all the impaired elderly in the community, and not only to indigent elderly, the needed personal and domestic home care services. Eligibility will be determined on the basis of professional functional assessment of the elderly by an interdisciplinary social work-health team. When the needed in-kind services will not be available, a cash grant will be provided. The law is unique in several respects: it is aimed at combining an equity principle with some form of means test; it is aimed at minimizing institutionalization by helping and encouraging families to maintain their caregiving role. Thus, a study on family relations and changes in the care-givers functions and responsibilities will contribute to understanding the process when caregivers start contemplating institutionalization.

The existing literature, which is still limited, reveals the elderly and their families who cope with a decision process regarding institutionalization are exposed to tensions, emotional and value conflicts and lack avenues of support and basic information which might help them make the right decision (Ruth Mary, 1984; Schofield & Bass, 1986; Clark & Associates, 1986).

The pressures we observed on the workers manning the information placement service described above, and the first steps toward implementation of the Nursing Law, led to the decision to undertake this pilot study. Forty-two elderly and their families were randomly sampled from the files at the information placement service. Included were elderly with children who were referred for further contact to one of the welfare bureaus. The study population included the 42 elderly, one of their children and the social worker who treated the

family. Indepth personal interviews were conducted, gathering data on socio-economic characteristics of the elderly and the families; health and functional status, use of support networks, attitudes towards institutionalization, amount and quality of contact with the social workers; family relations prior to thinking about institutionalization and the impact of the process on family relations. Data were also gathered from the social workers on the stages of the treatment process, knowledge and use of alternative community services and attitudes towards institutionalization. Most elderly (about 90 percent) had health and functional problems which impacted on the decision to seek the institutional solution, combined with other crisis situations such as widowhood and loneliness. Assistance was mostly provided by the children who felt overburdened, pressuring the parent to think of relocation. The workers try to help the elderly and the families by offering and referring them to available services. However, since the array of community services, especially for the home bound, are limited, needs could not always be met. About half of the elderly and the families expressed satisfaction from the contact with the workers and wanted increased contact. The main services which families and the aged felt might help the parent to stay in the community were: home help and home makers, volunteer services and help with housing. Family relations emerged as the most significant variable affecting the process of decision making with respect to institutionalization of a parent. The older the child, the more educated he is and the better the family relations (measured by a 10 item scale developed by Olson, 1979), the more difficult and prolonged the deliberations over whether to institutionalize. The better the

family relations, the more guilty, anxious and ambivalent the children felt and the harder was the decision for them.

The basic results presented above illustrate that a decision about relocation is a process with several stages. Moreover, following up on these 42 elderly about six months after data collection, only a third were in institutions. It seems that we need further data in order to understand the complexity of the decision making process and the variables influencing this decision. We need to refine more instruments to identify different life styles of elderly who might be at risk regarding institutionalization, as well as studying value components that impact on interactions within the families and client-worker interactions. On the practice level, more carefully planned interventions should be developed such as creating various family support groups; providing more information and helping elderly and families "to get to know the system," especially the long-term care system; providing training programs for the workers in this area.

I am working now on preparing a manual for professionals in the field, working with families of the elderly around different crisis situations, emphasizing this area of relocation.

I want to conclude by sharing with you the wonderful experience I had while visiting Florida. Dr. Sheppard provided me with the opportunity to visit and learn about some of the services, representing the main points along the care continuum, as well as meeting with professionals involved in teaching and research in Tampa and Gainesville. As the time approached for my leave, I felt how short it was, and how much more I would like to learn, to see and

experience while sharing the developments in my own country. Again, I want to thank all of you who make this trip a challenge for me to come back and learn more thoroughly about your different programs. Again, special thanks to Dr. Sheppard for his invitation, and for his gracious and warm hospitality.

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